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The official bulletin
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of The Massachusetts
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Bruce B. Stoler, M.D.

Your President's Page

MEDICAL ETHICS

Ethics: A distinctive mark of a profession and a source of the confidence that it engenders is its ability and willingness to specify and justify standards by which its conduct can be judged by its members and by society.

Dr. A. J. Dyck

This issue of the Hippocrat addresses the one subject which affects the physician's relationships with his colleagues and with the public more than any other—medical ethics.

Previously a rather static subject, traditional medical ethics has been challenged in recent years from multiple powerful and somewhat surprising sources:

Item: The medical profession is still reeling from federal attacks on ethical guidelines re: advertising by physicians and on the use of relative value schedules for judging the fairness of a fee.

Item: External forces within some hospitals wish to take the place of the physician in decisions as to which of our patients shall have resuscitation.

Item: The Supreme Court will soon attempt to define under what circumstances abortion is murder.

Item: By giving us the ability to prolong the act of dying, the new technology has resulted in a landmark court decision as to when it can be terminated.

Item: The availability of expensive new diagnostic technology, to "prove" the diagnosis which is "only" 98% certain on clinical grounds, raises a real ethical dilemma regarding justifiable costs of medical care.

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Seventeen years ago when I first entered practice in Hampden District there was an ethical prohibition against even looking at the medical chart of another physician's patient unless your consultation had been requested. Now-a-days non-physician auditors for third parties, PSRO Committees, paramedics of all varieties, insurance clerks and even the patients themselves are entitled, by law, to a copy of the medical chart to review, challenging the privacy of the physician-patient relationship, a basic ethical premise of good medical practice.

One of my first acts as your president was to request the Medicoreligious Committee to take a fresh look at the ethical underpinnings of medical practice today with a view to developing recommendations for new ethical and moral guidelines for the membership of the society for the future. Doctor George Bronos and his committee will make this report to your Executive Committee for publication in the Hippocrat when it has been completed.

Bruce B. Stoler, M.D.
HDMS President 1976-1977

Your views on the smoking resolution are solicited. Just write to the editor.

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Highlights of the Executive Committee Meeting

November 17, 1976

The Executive Committee met on Wednesday, November 17, 1976 in the Conference Room of the HDMS.

Present were Drs. Stoler, Verrilli, Bloom, Stoddard, Walthall, Smith, Teale, Magill, Remsberg, Sachsse and Mrs. Purdy. Dr. Stevens was present as a guest.

The minutes of the October 19, 1976 meeting were read and approved as read.

A letter from Western Massachusetts PSRO was read. They would like five physicians to serve on a Committee on Long Term Care. These men will be contacted for their willingness to serve.

Lifestyle, a program on weight loss, was discussed. The committee agreed that it was acceptable as long as it is physician supervised, as this program is.

A letter asking for documentation from three physicians who list themselves as gynecologists when they are surgeons, was considered by the committee. It was decided that in the next Newsletter the members should be reminded that when listing each be sure he is trained in any specialty which he lists and spends a substantial part of his practice in this specialty.

A letter regarding submitting patient's personal data to the Welfare Department was read. The corresponding physician feels the patient's privacy is being invaded. After discussion it was decided that this letter be referred to Dr. Corsaro to be presented to the Committee on Tax Supported Medical Care.

Dr. Stephen Paul wrote to request HDMS support for the decision of the task force of the WMHPC re: the numbers and locations of additional cat scanners in the area. After much discussion it was agreed to have Dr. Paul give his views at the District Meeting on November 23rd. It was voted by the committee that physicians are in favor of whatever will permit the highest quality of medical practice in this area.

The smoking resolution had been referred to Dr. Memery, Chairman of the By-Laws Committee, for consideration. His committee feels that only a simple majority is needed for this to be a standing rule of the society. It will be presented at the District Meeting on November 23rd.

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Dr. Bloom, PR Councilor, reported on several items of business concerning public relations. A follow up on the coming TV program has been finalized. A pilot program will be set up and the program will start in about six months. The PR committee had met just prior to the Executive meeting and considered the charges made to it, namely, the Society mission, identity, goals and position of the HDMS in contemporary society. This will be studied further by the committee and will be presented at a future meeting of the committee. A meeting with the news media will be held on Wednesday, December 1, 1976 to discuss the advantages of one well informed reporter to do medical writings for the local press. The programs for radio will be reinstated with WSPR, which were done a few years back. The telephone program, being planned by the committee for medical assistants, will be updated and a definite date planned for spring.

There were no reports from the Legislative Committee or the Public Health Committee.

Dr. Verrilli reported on the Peer Review Committee meeting for Impaired physicians. The MMS has started to study this through their Mental Health Committee.

Dr. Stoler reported on the Ad Hoc Membership Committee meeting held in October. Prospective new members will be invited to attend District meetings. Some suggestions are decals for car windows and medallions for license plates with the seal of the HDMS on them. Cards will be issued to new members with the mission of the HDMS as outlined by the PR Committee. The Publication Committee of the Hampden Hippocrat is functioning and will have a meeting soon. Dr. Stoler reported on a meeting that he and Dr. Verrilli had with Mr. Hooven and Mr. Roche of the WMHPC.

Mrs. Purdy reported for the Mediation Committee in Dr. Lynn's absence. They meet every month and hear an average of six cases on ethics.

The Springfield Academy of Medicine sent the resolution made by their board about the fact that they will lend support to the Ad Hoc Committee of the HDMS that is studying the possibility of a merger.

The meeting was adjourned at 10:25 P.M.

Submitted by,
Philip Stoddard, M.D.
HDMS Secretary 1976-1977

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The Page of the Auxiliary to the HDMS

December 1976

An executive board meeting was held on November 16. Reports on White Cap finances were presented by Elsie Caldorola and Helen Atamanian. Elsie reported profits of $1,790.68 from the ball and Helen reported $1,127.21 from the raffle. Elsie and her committee pictured above are to be commended for the hours of hard work that helped to make the evening the special event it was.

Helen listed the raffle winners. They were:

Dr. and Mrs. Ziter, Bermuda Trip
Dr. and Mrs. Zacarian, Wedgewood China
Dr. and Mrs. Navazio, Case of Wine
Dr. and Mrs. O'Neill, Wristwatch
Dr. and Mrs. Sher, Lavin Perfume

Helen had spent hours keeping track of tickets sold so that we could accurately report and pay our taxes to the state on the raffle. Thank you Helen. Any of us who have ever filled out government forms know what a time-consuming job you had to do and you did it so well.

Mrs. Wenda Restall, Historian, at 567-8668 asks that you check your bookshelves to see if you have the Auxiliary Scrap Book. Please call if you have it or have an idea where it is.

Many members of the Auxiliary and their friends participated in the Swine Flu vacination program. They were: Diane Abassy, Cynthia Bye, Patricia Driskill, Sallie Hendrick, Ruth Kenler, Shirley Lemlin, Laurel Libby, Dorothy Mozden, Barbara Pahl, Dorothy Schwendenmann, Betsy Stevens, Carol Tractenberg, Louise Zadworny, Carol Yorzyk.

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FEATURED ARTICLE:

Medical Ethics and Discipline

by Alonzo D. Sheffield, M.D.

The issues and new questions which now confront the medical profession such as abortion, euthenasia and the use of extraordinary resusitative measures in the terminally ill (to mention only a few) present perplexing, complex and awesome ethical subjects. These problems require the sustained and serious attention of competent professionals with clinical experience who possess integrity and a sense of responsibility and who bring a variety of perspectives as well. These philosophical subjects are not the intent of this article. Upon receipt of my editorial assignment, I readily comprehended the enormous scope and my limited comprehension of this subject. However, in attempting to fulfill my assignment I wish to submit for consideration certain questions concerning some of the ethical and disciplinary aspects of the present day physician-patient relationship.

Quoting from Derbyshire's article about medical ethics, which I shall allude to frequently, he states: "Although the principles of medical ethics of the American Medical Association serves as a guide to the acceptable behavior for physicians, the medical practice laws go beyond this. Most of them define some variety of unprofessional, immoral or dishonorable conduct as a cause for disciplinary action. Only ten laws, however, refer specifically to unethical conduct." Definitions of ethics vary, but essentially all recognize ethics as rules of conduct applied to a particular group such as physicians. Although ethics is described as a science of morals and morals are the practice of ethics I shall use the terms unethical, dishonorable, immoral or unprofessional interchangeably as far as the interpretation of the law is concerned. Patients predispose that we will observe moral and medical ethics. Understandably, they come to us with the assumption that the physician will exercise his expertise ethically and not only for mercenary gain. Recent media publicity cited some spectacular abuses in the Medicaid program. An editorial written by Jerry Zaslow, M.D., J.D., F.C.L.M. speaks to the problem in The Journal of Legal Medicine Nov./Dec. 1976 under Medicaid Abuses. "The publicity given to Medicaid abuses has brought into the open actions on the part of some members of the medical profession that are not only illegal but demonstrate a total disregard of the principles to which physicians have dedicated themselves for centuries.

"The American Medical Association recently issued a statement that all physicians guilty of such conduct should pay the full penalty of the law. Regardless of the activities of any other individual in the perpetration of such frauds, the fact remains that if the health care professionals do not participate in them, the abuses cannot occur.

"The health care provider is the keystone in the entire system. The haphazard methods of examining and treating patients and the ordering of totally unnecessary tests (some of which are not even done) are abhorrent to the ethical principles of the medical profession. It is no excuse that these

Ernest A. Byron, Jr.

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SPRINGFIELD

activities are the result of a payment schedule that is inadequate. When a physician enters into the care of these patients, he does it voluntarily, and he should be commended for it. However, if his motive is economic gain alone, his act should be deplored.

"Obviously, an individual must earn a reasonable wage in whatever pursuit he is engaged, and participating in care for the economically deprived should not penalize but should adequately compensate the physician for his efforts. Regardless of the bureaucratic chaos that hampers the system the physician should not stoop to inadequate medical care and defraud the system. This only makes worse the confusion and inadequacy of care.

"While attempts at reform of the system are made legislatively, the physician should conduct his activities in a meritorious manner. Behavior of the type being exposed can only bring the wrath of the public down around our heads and force us into a system so replete with controls that the cost of monitoring will far surpass the cost of much-needed medical care.

"In addition, physicians who became aware of abuses of the type demonstrated here should not hesitate to report such activities to the appropriate medical society, if the suspect physicians are members of that society, or to the board of licensure for action."

According to Derbyshire's article the main agencies responsible for enforcement of discipline in the medical profession are the hospitals, organized medicine and the state licensing boards. The medical profession as espoused by Derbyshire has long insisted that it can best police its own ranks and it should. Yet unless all the agencies involved in medical discipline work together to improve their methods, "outsiders" conceivably could take over the control of medical discipline.

Dr. Franz J. Inglefinger has remarked that public confidence in medicine has progressively diminished, and the rank growth of malpractice litigation threatens common sense patient care. There is increasing societal recognition that the rights and dignity of the individual must be protected, hence medical ethics today must deal as competently and exhaustively as possible with the concrete features of actual moral decisions of life and death in medical care. Patients have opinions on medical ethical questions and physicians are bound to properly invoke ethical principles to defend the rights, dignity and health of individuals or groups.

Having defined the terms and alluded to the standards of the medical profession we might ask, how effectively are the various disciplinary agencies upholding standards. First, the hospitals; their awareness of ethical problems probably is a result of the Joint Commission and Accreditation of the Hospital and recently the peer review programs. It has been found that the effectiveness of the committees varied widely and of course the standards are no better than the effectiveness of the committees. The landmark decision of Darling vs. Charleston Memorial Community Hospital undoubtedly provoked and may have been responsible for the hospital administrators assuming more responsibility for the performance of their staff members. The decision stated essentially that the hospital administration may be responsible for the competence of staff members. It was noted that a large number of hospitals did not demand certificates of competence from the physician who wishes to resume practice after suffering a severe illness. Regan's suggestion that hospital by-laws should provide that staff members be required to submit reports of physical examination that specify ages is indeed sound. The inevitable question has

The failure of disciplinary functions of organized medicine is illustrated by the American Medical Association who in 1969 abandoned its project as a waste of time. There are grievance committees of the hospitals but, they had been generally found to lack the initiative in action. It has been observed that the medical societies have failed to realize that they have important investigative functions and they are not using them effectively.

But in the context of contemporary society, specifically its expectations and cognizance of our changing times, basic challenges are evolving as to the constitutional rights of practitioners as well as those of the more important patient. Our patients expect more, perhaps as a result of available information which has been exploding upon the public by all forms of educational measures and this results in a patient who can make better value judgments than formerly.

It was also the opinion of Derbyshire that organized medicine did not adequately discipline the unethical physicians. The final regulatory power lies at least for the time being not with medical society but the state government and obviously this may change with impending legislation. There is the fact of the inadequate reporting on disciplinary procedures which was succinctly stated by Inglefinger as follows: "Realize the predicament that should be sensed by any person who undertakes to accuse a colleague publicly of unethical conduct. What special insight or superior moral sensitivity gives me license not only to accuse but to judge?"

The confidentiality of the physician-patient relationship has been threatened and has already been significantly weakened due to a number of persons inspecting and preparing office and hospital records. I quote Inglefinger again "The goal of confidentiality, moreover, should be viewed in context. As far as I know, most of us are the subjects of dossiers compiled by businessmen, by credit bureaus and, often enough, by government. In such dossiers the nosey can discover our foibles and faults listed not only

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relentlessly but at times erroneously. Countless people already have access to hospital records, and once peer review and national health insurance are the order of the day, privacy will be further eroded. To worry in such a setting, where solvency, sobriety and sex life may be recorded in minute detail, about someone discovering that our urine contains oxalate crystals is like pulling down the shade in the room completely bugged for sight and sound."

There is a matter of ordering our medical priorities and ordering our overall social priorities, including medical needs in some more rational way. Indeed who shall say or how do we go about deciding what sorts of medical services should be given priority over others and how much of the nation's resources should be spent on medical care in comparison to other claims and needs. This issue must at least be lifted up to view, since there can be no good reason and no good moral reason for a decision by indecision, for allowing medical priorities and social priorities to be determined by who has the most spectacular therapy or the loudest voice in the land. To what extent ought medical needs be served in comparison to erradicating poverty, stopping the decay of our cities, depolluting our atmosphere and streams, defending the nation and aiding underpriviledged undeveloped peoples. ". . . No test will ever tell us whether our choice between a dialysis program and an equally expensive program of preventive medicine was right or wrong. Individuals will differ in their evaluations. If one man believes that 100 healthy children are a better investment than keeping one oldster alive on dialysis, his colleague who disagrees cannot claim his friend is wrong. They could, of course, agree to settle their dispute by attempting to measure the community consensus. But who then can say the community consensus is right or wrong."(Bazelon, David L., "Medical Progress and Legal Process").

"It would be good to hear the medical profession debate thoroughly and in public the question of ordering the medical priorities and how this ordering should be determined. That may be too much to expect, but if it could happen the people might learn not only the direction in which to throw tax money for medical research and the distribution of medical services, but also how as a people we should go about deciding the nation's priorities in general."(Ramsey, Paul, "The Patient As A Person" p. 274).

The patients as well as the media regularly refer to the "cost value" and "benefit risk" which require judgments and evoke moral and philosophical discussions daily during the course of our diagnostic and therapeutic plans for patients in many of the contemporary forms of aggressive therapy. Fidelity must of course be established between the physician and the

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patient in order that he may obtain informed consent for these medical treatments, and some of us will recall at least the sentiment of the passage from the Hippocratic Oath, "I will follow that method of treatment which, according to my ability and judgement, I consider for the benefit of my patient and abstain from whatever is deleterious and mischievous." Current additional consideration must be given to diagnostic procedures that provide the critical data for the management of the patient with the least risk and cost to the patient. This also applies to therapeutic procedures where the benefit risk ratio is marginal. As aptly expressed by Dr. Conn of Yale Univ., over the past several years a variety of new and ingenious techniques for the differential diagnosis of various diseases have been developed. In general the benefits appear to be proportional to the risks of each procedure. In some instances the higher benefit to risk ratio suggests a diagnostic bargain. In others a low benefit to risk ratio indicates an overpriced procedure. Our ethical problem of course is to pursue the safest and utilize the most efficient manner with which the maximum amount of information will be obtained. Lastly, the information should justify the expenditures or methodology.

I do not know the answers to these problems but this is a plea for fundamental dialogue between the urgent moral issues arising in medical practice within the framework of the ethical and disciplinary structure which supports it.

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Alonzo D. Sheffield, M.D.
Associate Editor

Some of the ladies who made the White Cap Ball the HDMS Fun Event.

Helen Shah Elsie Caldarola Terri La Pierre Helen Atamian

Ethical Dilemmas in Medicine

by Roberta Berrien, M.D.

Not very long ago a name in the obituary column of the local newspaper caught my eye. Mr. J_____ S_____ had died at Belchertown State School. I wasn't surprised. When Mr. S_____ arrived on my service at the Baystate Medical Center last spring, he already carried the diagnosis of acute myelocytic leukemia. He was sent to us for cancer chemotherapy. After my intern and I reviewed the history that had been sent to us by Belchertown State School and had attempted to do a physical exam, we were struck by two things. First, although he had reached a physical age of 67 years his mental age was less than 1 year. Second, he was almost unapproachable, continually flailing his arms about and being generally uncooperative in every way. Considering also that cancer chemotherapy is both difficult to administer (requiring continuous IV infusion, for example) and very stressful to the patient (causing hair loss, bleeding, nausea, possible severe infection with chills and fever), it seemed clear to us that to proceed with treatment would have been cruel and unwarranted. The decision, of course, was ultimately not the resident's and intern's to make. The responsibility lies with the attending physician. Several days of debate ensued. The question of the hospital's legal obligation to treat the patient was mentioned. Refusal might have meant a court case. The "easy way out" would be to attempt treatment in some form and not make an issue of it. We persevered, the attending physician agreed to back us up and we refused treatment. Indeed the case did go to court. The judge was made to understand the issues involved, and the case was won. Mr. S_____ was sent back to Belchertown State School to die, without being made miserable in the end by treatment which certainly, in his case, could not have been successful.

I have described the above case in detail because it is illustrative of the kinds of situations physicians find themselves in throughout their careers. Decisions must be made, based not on medical facts alone, but on larger philosophical issues as well. Even a House Officer just out of medical school frequently faces such situations. For example, in our hospital we have an excellent 5-bed CCU. There are many medical challenges involved in taking care of patients in that unit. The philosophical problems arise because of its relatively small size. Often the unit is full and another patient is brought to the Emergency Ward with chest pain. Which of the 5 patients must have to make room for the new one? Or should the new one go to a general medical floor? Should the man in bed 5 be transferred? After all, he is "quite old—over 70" and the patient in the Emergency Ward is "only 55." Or shall we send out the lady in bed 3? She has no relatives and no friends have been in to visit either. And the patient in the Emergency Ward has a large family that is hovering nearby. Daily we make these decisions, and the answers aren't found in medical texts.

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On the general medical floors, we often have patients with terminal illness, be it cancer or end-stage heart disease or liver failure. What do we tell these patients about their prognoses? If death is imminent, how do we proceed with letting the patient know, and how can we best help him to prepare for it? What do we tell the family? In the Emergency Ward we might see a patient with a long history of severe chronic obstructive pulmonary disease arriving *in extremis* possibly dying without respirator support. Do you intubate a patient whose lungs are virtually destroyed, who was just discharged 3 weeks ago after a 2-month stay in the ICU and who probably has "no hope" of being extubated ever again?

The list of moral dilemmas doesn't end here. What I would like to consider now, however, is whether or not there is any rational basis for our decisions. One day last week I asked a large group of medical House Staff if, in medical school, they had had any formal discussion of ethical problems in medicine. There was only 1 affirmative answer, and this person added that although an ethics course was taught, essentially no one bothered to show up for meetings. After examining my own feelings, I find two major influences on my decision making process. First is my desire to "do the right thing." All of us have good intentions and try to choose what we feel is best for our patients. What is most hard to define is how we determine what is "right" in our own minds. Our different backgrounds (with the various influences of family, religion, liberal arts college education and medical school) must mean that what one physician concludes is "right" is not necessarily what is chosen by another. One way to see how close we've come to other people's conclusions is to watch how other physicians handle similar situations. This leads to what I feel is the second most important factor influencing my decision process; that is, the actions of role models in the medical community. I try to carefully watch attending physicians,whom I respect,to see how they handle philosophical problems.

What I am most concerned with at this time is whether or not such an informal learning process is effective. I tend to feel that it is not adequate for such complicated problems. Often a third person (the House Officer) is unable to see directly how a private physician talks with his dying patient or the patient's family. Or perhaps the internist may be unable to divorce himself from personal involvement with a patient he has known for years and thus be unable to accept this patient's imminent death and deal with it appropriately. Or the physician might be involved in an active practice and opt for the "easy way out," i.e. treating a patient like Mr. S_____because refusal might mean time spent in court and away from a busy office.

I feel that there would be a tremendous amount of insight to be gained from regular discussions of ethical and moral problems in medicine by physicians in all stages of their careers. Pooling experiences, discussing decisions and trying to understand them on a rational level might help all of us to have more sound judgment in the future. Certainly, there can be no definite rules for such decisions, but guidelines can be helpful. I would like to see non-physicians involved in those discussions as well—families of patients who were involved in difficult situations, clergymen, philosophers. There are legal implications to many of the decisions we make, and the advice of the legal profession would be helpful as well. I feel that these ethical problems are a challenge we must prepare ourselves to meet with as much seriousness and effort as we give to keeping up with the medical advances in each of our fields.

Roberta Berrien, M.D.
Associate Editor

FEATURED ARTICLE:

"The New Year: The New Generation"

by John J. Zadworny, M.D.

As we come to the end of the old year and the beginning of the new year one cannot help but reflect on the notion that with the beginning of the new year, we are seeing the beginning of a new generation. With that new generation, we will face as in the past, a conflict between the new generation and old generation. One of the most serious sources of the conflict today between the old generation and new generation is "structure." The two generations are not easy to define. They cannot be defined by age, by education or by class, but there is one fairly reliable guide for grouping them; their reaction to this thing called structure. The old generation accepts it; the new generation questions it. There are irresponsible ones among the new generation just as there are obstinent authoritarians among the older generation, but there is serious lack of understanding and communication today between the genuine people on both sides. Both must find a way to work together if today's problems are to be solved. To solve these problems, mutual understanding must be found in the different way each looks at structure.

To the new generation structure is the set up. It is the fixed approach to any situation. It is an attitude of mind and an elaborate set of procedures presented as the established way of doing things. As an attitude, structure is coming to a discussion with a final decision already made, approaching a new situation with a pre-established plan, replying to an objection with an appeal to authority, attempting to solve today's needs from past experience only and being reluctant to admit that the new generation might be able to discover some better ways to meet their needs. The new generation can sense structure immediately; the older generation finds it hard to pin it down because they take structure so completely for granted that rarely is it considered anything but common sense. It is codes of conduct ranging in scope from basic morality to talking too loud; it is laws governing everything from murder to stop signs. It is a change of command, the remote control, the unbending remote impersonal establishment that seems more concerned with enforcing old laws than it is with meeting the new needs. The structure that the new generation objects to is not revealed truth, devine law or authority. Nor are they questioning authority as such or the right of authorities to formulate laws and administer them. What they do object to is the misuse of authority in treating all aspects of structure as immutable and backing this stand with authority. They insist that even if tradition or eternal truth can be invoked to support some methods of procedure in the past, adaptations or totally new procedures must be devised to meet genuine new needs.

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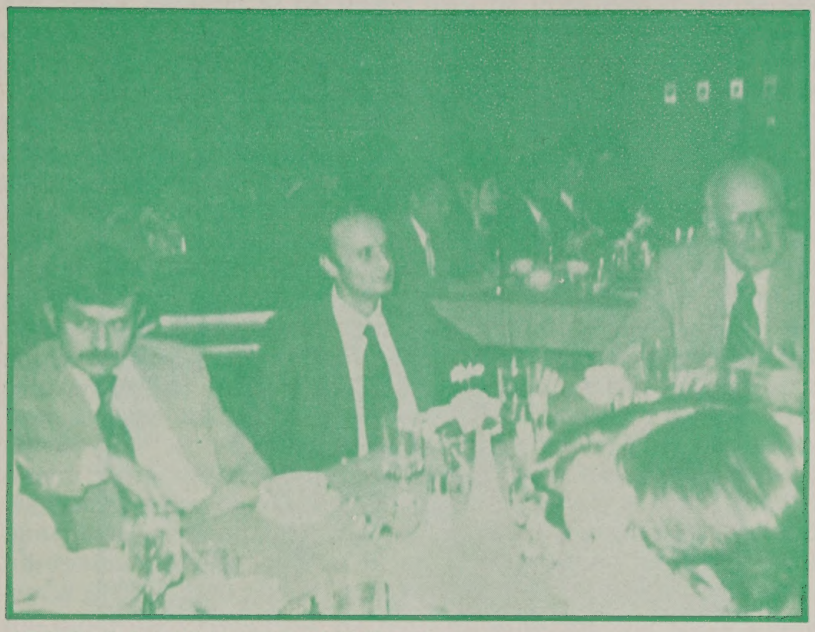

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It is important to realize that this new generation really has something to say. Their demand to be heard may be upsetting to those who defend structure but hear we must or we will face a permanent movement in history which will bring forth a struggle as has happened so many times before.

In order to understand the new generation let us look at the world from their side. The new generation looks upon itself as one that has grown up in a world of insecurity and uncertainty amid unlimited power of production and destruction. It doesn't know the solution to all the problems but it does know that the older generation doesn't know all the answers either. It sees the U.N. in constant debate. Labor and management are in debate. The church is in almost constant debate. Educators, politicians, economists, military strategists, art critics, religious leaders are in constant debate. The new generation has seen almost every value in human life from the most sublime theological concepts to the latest methods of warfare submitted to re-examination within one generation. If the older generation concludes from this that too much criticism causes all this unrest, the new generation concludes that too many things need criticism. The new generation has heard that America is the greatest land of freedom and prosperity and has learned that one-third of it's people is helplessly impoverished. They have been lectured to on the common good and have witnessed all too common hardships of individuals for whom nobody cared. They know that half the world goes to bed hungry every night and that overweight is a problem to the other half. They hear sermons on what faith can do for them and they know that much of the human race couldn't care less. They are unmoved by generalizations about society, common good, eternal truth which they know have left individuals helplessly in tragedy. They are extensionalists and personalists. They are not selfish individualists. To them "person" means the human center of a complex of relationships. They know they are not fully persons until they fulfill the potential of their entire personality. This does not mean abstract duties to the abstract human race. It is literally love of one's neighbor, black, white, rich, poor, privileged or destitute. It is sharing; it is experiencing as a person the life and love of other persons at church, in work, at play, in conversations, in love, in poverty, at every level. They do not want to start with conclusions and outlines the older generation inherited, accepted, tried and couldn't make work too well. They want to work out many things for themselves. They do not trust formulas of wisdom handed down to them. They want to acquire their own wisdom through the only way it can be acquired—personal experience.

The older generation shudders at this immature approach to the complexities of life. It would like to shield them from the mistakes of the past as far as possible. It would like to prepare them for the responsibilities to the future but at the same time it would deprive them of the risks and hardships that are necessary to produce wisdom. In the eyes of the best and most discerning of the older generation, the new generation doesn't seem to realize that one day they, too, will need order, obedience, continuity, sacrifice of individualism for the common good, moral laws, dogmatic truths and a stable society based on laws and the acceptance of laws by the community. The new generation appears too impatient, too inexperienced to appreciate the necessity of these values. The new generation gives the impression of wanting to be allowed to think and act as though nothing that has ever been learned from experience in history is applicable to them; as though nothing of the past is valid for the present; as though each generation must begin over from scratch because life wasn't perfect before.

To many, some of the new generation are not willing to start so completely over that they will go back to the frontier log cabins, homespun cloths, cold water and wagon trains. Lots of them like scholarships, allowances, universities all set up for them, government subsidies, credit crds, libraries, automobiles, places to go for which someone else pays taxes. They are willing to join the peace corps and the service groups but they are apt to forget that millions of dollars and years of work by other people who accepted structure had to be enlisted to make these programs possible.

The older generation will give credit to many of the new generation who are willing to live in slums, give up vacations, live on next to nothing, suffer with the poor they serve and strive heroically to equip themselves to be of service to the underprivileged, but far too many of the new generation seem to want to experiment with life and learn for themselves, within the framework of an established society whose values they reject. They are willing to face, now, the possibility that their present ideas may not work out. They are not quite willing to see that, if their generation fails at least one more generation after them will fail too through their fault. The new generation runs the danger of putting too much hope on untried experimentation. It prefers person-to-person relationships and small group associations because they are not complex and need no structure, but it fails to see that society cannot survive or progress if it remains as just so many cells disconnected, unrelated, unorganized toward the good of the whole body. It fails to realize sufficiently that, by demanding only its own approach, it may be seriously jeopardizing continuity in human life. Among the things certainly to be recognized as worthwhile and necessary in human life, two should be emphasized here: the right of a person to develop in his own world and the right of the next generation to start out with a measure of security in life. Overinsistence on structure can prevent the first. Total denial of any structure can destroy the second. Order and freedom, structure and experimentation, continuity and personal fulfillment, these are the values that must be balanced in any intelligent human growth. The rigidity of structure has to go but some structure is necessary. The older generation wants to start with structure and yield as little and as slowly as possible to change. The new generation wants to start with free discussion and concede as slowly as possible to a minimum of structure in the end.

Can there ever be a meeting of minds between these two generations? We have no answer, but it would be tragic if both sides don't try, for mankind needs very much of what both are trying to achieve from opposite points of view. Great harm can be done by those within the structured system who wants to extend authority and restrict freedom in defense of an immutable

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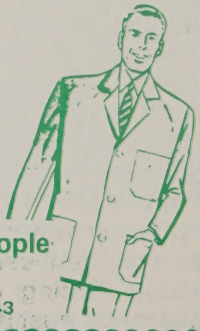

historic structure. Equally great harm and great loss can come to this new generation and to the successors, no matter how exhilirating the present adventuresome atmosphere of revolt is, if they leave to prosperity no progress, no conclusions of their own or anyone else's and can only say to their children and descendents; Well, we tried. We have nothing to tell you from our experience except we enjoyed it. Anything else would be to revert to structure. You will have to find out everything for yourself. We have had our experience, now it is your turn to have yours. Nothing can be handed on, start over and live your life.

What is the answer? Each generation exaggerates the faults of the other's position and tends to idealize it's own virtues. Each side wants to preserve certain values and to eliminate certain dangers. The older generation wishes the new generation would be more concerned about law and order. The new generation wishes the older generation cared more for freedom and personal fulfillment. As long as we stand apart this way, there will never be a meeting of the minds and as the old year passes and the new year begins, let us hope that representatives of both sides come together; but not until a considerable amount of homework is done. Regardless of which generation you belong to, try stating the position of the other generation as you see it. State explicitly it's values and it's weaknesses. Then do the same for your generation. After this is done, exchange your statements with representatives from the other generation and let each edit the other's copy. Point out what they have misrepresented but face up to their criticisms if they have validity. Then try to come together. There will be much disagreement for awhile and much discussion but we must narrow the gap. Each side can learn from the other only if we come together in charity and in truth. If we do this, we can indeed look forward with comfort and confidence to a new year and a new generation.

John J. Zadworny, M.D.
Associate Editor

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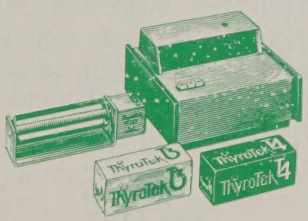

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FEATURED ARTICLE:

1984 Revisited
Allegory Alleluia

by Howard N. Simpson, M.D.

Tom was there with his familiar welcoming smile when I stepped off the monorail from Bradley International Airport at the Dwight St. Station. It occurred to me as I greeted him that it was eight years, back in 1976 in fact, since I had been in Springfield. There would be changes, perhaps greater than I might expect, for I had not only been away from this area but had spent most of the intervening time doing my thing in far away New Guinea.

Tom looked fine, a little paunchier, a little grayer, but otherwise the same amiable internist I had known in earlier years. After the usual pleasantries I said to him, "Unfortunately I don't have much time to spend here. The foundation I work for wants me to report what is going on, medically, all over the U.S.A. so I thought I would begin by seeing what has developed in this old colonial establishment in my absence."

I thought Tom seemed to shudder slightly, but I pretended not to notice. "You may observe some changes," he allowed. "Let me show you." He showed me. Changes there had been. A large area adjacent to the old railroad station had been cleared and a modern multistoried circular building had been erected. From the outside the most impressive feature of the structure was that from several directions monorail cars could enter an upper story. Later I discovered that these conveyances shuttled to and from the various hospitals in much of western Massachusetts. Tom conducted me into the rotunda, resembling a busy subway station, where patients on litters were being shunted in and out on cars which paused only briefly to discharge or receive their human cargoes.

"In this building," said Tom, "is where all diagnostic procedures and all definitive treatment is done. All the surgery, chemotherapy, intravenouses, physiotherapy, parenteral medications, you name it, it is done here." I did name it. "What about radiotherapy?" "Done here, but all handled by technicians. Keypunch operators and computers." I promptly subsided. "You see," my informant continued, "the hospitals you were familiar with now provide the patient with a bed, meals, a basin so he can bathe himself, water for his flowers, thumb tacks for his get-well cards, two chairs for his visitors and a large reel of red tape. Everything else is done here."

"Who pays?" I asked innocently. "Oh, it's all free, that is, it's federally

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funded. The minimum wage is now ten dollars an hour and the minimum tax bracket is 45% and there are no deductions and no exemptions. That has done more for population control than 'the pill' ever did. The state income tax starts at 20% and the local income tax is 5%."

"I would think some patients might spend more time traveling than they do being treated." "Well to a certain extent. But we don't have as many chronics. The genetic manipulators, we call them 'gene tinkers' have eliminated many congenital defects. Sometimes they goof and the results are horrible—but dispensable. The greatest advances have been in virology. Many neurological ailments, multiple sclerosis, amyotrophis lateral sclerosis and several of those disorders with two or three Frenchmen's names attached to them turned out to be due to slow viruses, so slow immune vaccines are used to cure them. Furthermore the spinal cord can now be transplanted, if you can find a fresh one the right size. Then about cancer, the Surgeon General finally got off his duff and instead of merely mumbling that smoking was injurious to your health he persuaded Congress to outlaw smoking after he demonstrated that it was worse than swordfish or cyclamates. Then it was proven that the increase in cancer incidence was due to the appearance of many new viruses, so the development of antiviral immunizations have now solved many of these problems."

By now I was in a slight frenzy. "What about surgery?" "Let me show you." He led me to a large circular room. There were at least a dozen operating tables, perhaps more, arranged so the heads of the patients were toward the periphery of the circle and on each head was a cap with electrodes attached. On the inner core were outlets for various solutions with conducting dispensable plastic tubes leading to each table. All of the salts from aluminum to zirconium were available as well as blood fractions both human and bovine. At the foot of each table was a middle person to turn the appropriate valves. Tom told me that in London the surgeon merely pressed a button and the proper solution was delivered to the proper vein, but in this country the technicians' union had objected, so the only solution to the solution problem appeared to be for each table to have a control person to meet all demands on demand.

I then pointed an inquiring finger at the patients' head gear. "Anesthesia has taken strides since you have been in the bush," Tom announced with some asperity. "You remember about the brain waves that the electroencephalographers used to talk about. Well if you know how to do it you can introduce waves in millivolts that will neutralize, so to speak, the brain waves that are naturally being created, and you can anesthetize the patient—knock him cold, electrically, that is."

"Now wait a minute," I objected. "If you cancelled out all his brain waves that would result in brain death."

"Oh, agreed," said Tom, "this requires great skill. The natural brain waves are not completely

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neutralized, only about four-fifths. That is enough to produce lack of perception of pain, touch, etc. and allows the surgeon free reign."

I was still unhappy. "But these brain waves are different in every person. You cannot just turn a switch and neutralize Joe's waves with the same flip you would use for his wife."

Tom was unflappable. "Of course not. Before anyone is put under this type of anesthesia his EEG is run through a computer and the gadget is told to determine the proper millivoltage, the proper pattern and the proper timing to cool him. When the surgery is completed, the input juice is turned off, you give him a shot of his own pattern, he gets up off the table and if he is delinquent in his taxes you hand him a bill."

I was aghast. "This principle must have other uses."

"Oh it does, definitely. The psychiatrists use it all the time."

"Tell me more."

"Well the psychiatrists developed quite a lobby and got themselves a lot of legislative clout they never had before. If instead of using this procedure for an hour or so you continue the process for one or two days you can produce a very decided change in the psyche of the individual."

"Can you be more specific."

"Certainly. The shrinks discovered they could take an individual, let us say some one who was intolerant of the way things were going in society, or was protesting against popular social attitudes, or who was against racial imbalance, or against economic insecurity, or who had criminal tendencies, or who was fighting with his boss, or could not abide his wife—or husband, as the case might be—and all of these people could be given neutralizing brain waves, monitored by the computer, and they would all end up alike. They would be polite, calm, serene, never argumentative, create no disturbances. There was just one strange contingency. They retained their memories. Often these people would sit by themselves as if in a trance, watching the sunset or the distant hills. But they were always tranquil."

It was time for me to leave, and as I was about to board the monorail to go back to the airport I turned to Tom. "You have enlightened me a great deal and I appreciate your giving me the time. The changes since I left here are vast indeed. You have improved the efficiency and the speed of hospital care. You have discovered the cause of many obscure diseases. You are finally on the verge of true cancer control, the elimination of many congenital defects, you have made great strides in surgical anesthesia and technique, and in the therapy of nervous and mental disorders including personality problems. Chemistry, physics and electronics have literally revolutionized American medicine."

Tom was smiling, frankly, I thought, a bit smugly. "There is," I said, "one thing that puzzles me. Despite all these improvements in diagnosis and treatment your overall mortality rate is considerably higher than it was eight years ago. What now is your principal cause of death?"

"Suicide."

Howard N. Simpson, M.D.
Associate Editor

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Editorial:

Of a New President — And Things

This issue of your *Hampden Hippocrat* is focused on ethics and discipline and four of its associate editors have expressed themselves, in various manners and styles, on this theme. A common thread runs through each—the physician must do more to restore and rebuild public opinion in her or his personal and professional ethics. Ethics are those principles which directly or indirectly shape our actions within ourselves and with others and are accepted by many as the binding unwritten rules between parties or societies. Those ethics, foreign to us, are usually considered at first hearing or viewing to be undesirable, until analyzed in the context of their initiation and development. Witness the "golden rule" and its multilingual, multireligious and multiracial expressions. English common law, slightly seasoned by the code Napoleon, tempered by the Puritan concepts and dramatized by the Constitution is the anchor to which our interpretations of life's lessons are affixed and American Medicine attuned and from which reasoning of an ethical position starts.

November 2nd saw a national exercise in the evaluation of ethics (suspect or real), in which principles of party platforms, regionalism, desire to hold the status quo or move ahead, unknown candidate vs. a known performance, concern over the proper route for American Medicine and National Health Insurance/Service programs were weighed against the individual voter's goals for income and life styles. The difference and similarity of desire of two million plus voters has brought us a Democrat, Southerner, non-lawyer, ex-Naval now business man, Baptist, firm idealist who plans on restarting the economy and making life better for all Americans. Unfortunately, each party's and candidate's solutions to the country's needs and the related issues were submerged in a PR attempt to project the personality of their man, not his ethics or position thereof. At the end of the campaign, neither President Ford's nor Governor Carter's ethics and thereby the opportunity to predict future action were clear or definable; vagueness and generality prevailed. For the Massachusetts physician no satisfactory explanation, of how general or specific issues affecting him were to be attacked, had been set down in the public record. Issues such as inflation, unemployment, control of industrial and population pollution, rights to life or death, planned industrial and business growth and health care issues such as a National Health Insurance vs Service program, the training of members of the health care delivery team, what is a minority and how should it relate to the nation's health programs, the alignment of bureaucratic and organized medicine's plans for caring for the unreached, uncared for segments of Americans, self policing, consumer input to the health care delivery system,demand

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the beginnings of programs for their solution. For the moment, you and I must rely on the constitutionally described forces to winnow out the best from the worst solutions. Our vote is in abeyance for two years, but our typewriters and telephones are not. Now is the time to personally communicate with your legislators and convey to them your feelings on these and other issues, which you hold dear or vital to you and your patients' wellbeing—again the commonweal.

In western civilizations, we have alternated between killing those whose ethics differed from ours to smothering them with gifts to convert them. Today, neither approach seems justified or effective; restructuring is imperative. The ideas and ethics, like those which started and completed the American Revolution, swept the world not by force but by reason and were modified to fit the existing culture and ethic systems. The parliaments of the world need new ideas or modifications of old ideas to solve the crunch of populations, food, energy and lebensraum. Yours could provide the nidus for a needed new approach or solution. What follows are some ten problems of the American Society and Medicine that confront us and are in need of ethical and pragmatic analysis. Order does not indicate importance. The comments are those of the editor-in-chief's.

Problem #1. A National Health Policy

I know that American Medicine is second to none in providing care to the acutely ill or traumatized patient. I believe that private and federal research will eliminate additional rare diseases and reduce the kill rates of cancer, cardiovascular and gastrointestinal illnesses. Longevity coupled to a better quality of life will be extended to all Americans by the year 2000. But death must still happen to us all; where then should a national health policy aim? Currently the care of the chronically ill leaves much to be desired; facilities, personnel, know-how are all inadequate and financing is short of catastrophic. Insufficient attention or stress has not been made to the prevention of disease and mental disturbance. More general good and better health will result from study and the application of the findings than from continuing to patch up and care for people after disease, self-abuse or environmental pollution have taken their toll. Preventive health and medicine must be stressed in any new policy.

While individual care of the patient in the system is best, a significant segment of the citizenry does not get into the ongoing and current multidiscipline system. Whatever orderly policy is chosen must provide for universal care. The religious ethic of "take care of him and I will repay you" must be

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extended to sharing earnings or income with those less able to provide for themselves and their health needs—at the least cumbersome and costly way, in each community. The minimization of bureaucratic control, the assistance of the voluntary health agencies, the physician advisors to the regional Health Service Agency consumer committees, and the cooperation of and orchestration by organized medicine should be some of the objectives of the new health planners. To prevent runaway cost, all policy should be phased in, in tempo with economic indicators and not immediately as occurred in 1965. National Health Insurance and not Service is what seems best to me.

Problem #2. The Physician's Changing Role in the Health Care System

Until the half way mark of this century, the average physician was similar to a one man band—alone, controlling most of his instruments, calling the tune and its price and free to wander where he wished. Now he finds himself on the National Health Symphony stage struggling to remain the leader but destined (through lack of practice) to be at best the concertmaster or mistress. Numerous other health professionals are working and organizing to become the conductor; all convinced that they are better able to orchestrate and lead the National Symphony of Health Care. The physician by virtue of the fact that his day's job is to care for his patients has neither the training nor the time to compete with the professional whose day is spent dealing with the non-clinical problems of health care and its delivery. He is doing the job he was trained to do, thus placing the physician at a disadvantage that can not be corrected. Either the physician must give up his practice to do administration or work himself into an advisor's position, to become the power behind the podium while avoiding the assignment of a page turner. Here the role of organized medicine is clearly laid out for it. Through the recruitment and training of physicians or by providing a financial support that will allow both inhouse medical administration and health care team administration by full time paid physicians, it can put its man in the right place. I favor financial support for the officers of the three levels of organized medicine commensurate with the society's ability to pay and the complexity of the job. The future of the profession should not be compromised because a competent man or woman can not afford to take time off to do the job of running an organized society.

Problem #3. The Training of Ourselves and Our Successors

There is little need to reemphasize the need for all physicians to continue to keep up with the changing complexities of modern American Medicine. I favor the accumulation of 'brownie points' with a central state registry keeping tract and reminding us of deficiencies. A physician should not have to be reexamined periodically if he can show that he has kept up and his license and his speciality boards should be satisfied by the brownie point method.

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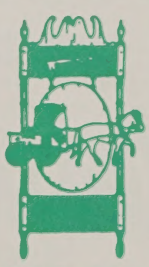

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Federal and state funds have greatly increased the numbers of medical schools and the number of graduates therefrom through the use of tax dollars. We are now told this free educational bonus to physicians makes them beholden to the system. I am not aware that only medical schools receive funding from government, who supports the University of Massachusetts? Some of the plans for increasing medical manpower before the Congress resign the new graduate to work out his or her bureaucratic indebtedness in regions where physicians are scarce, scarce because the principles of American economics excluded them. Except for the armed forces, no profession is or has been dictated to or manipulated as much as the medical, either during wartime or peace. Research and the training of graduate students should not be equated into the costs of primary medical education, but made to account for itself.

The concern of the medical schools seems as much financial as altruistic; confusion over who should be included as sons or daughters (applicable to the Hippocratic Oath) seems to exist. Now the professor teaches those who will guarantee the financial survival of his school. Is it the minority group which must be made into physicians? Or should we be looking for the embryo physician in all classes, races and degrees of humanity? The breakdown of humans into subgroups of various minorities can be carried into absurdity. A policy must be devised that assures all of a fair exposure to selection.

Medical education could be restructured, so that the shortages of primary care physicians is alleviated. After a classic college education to establish a broad base in physical and social sciences and the humanities, the future physician should receive three years of the

basics in medicine and after a year's internship go out and practice primary care wherever the market is open to him. After a stint of no less than three years and an affirmative nod from his county medical society and state licensing board, the embryo physician could apply for residency training in a speciality of his choosing. After appropriate formal and clinical education and the successful passing of that speciality's board examination, he or she could again go out into the medical market place and find a position. Should he or she wish to further limit practice by concentrating on a smaller segment of human illness, a third level of clinico-academic training could follow a five year clinical setting. He or she then would be a super-specialist working in a few select places or institutions. Many non-clinical forces will have been molding the physician to hold him at the primary or secondary levels of practice. Tertiary care would be only by experienced physicians who have spent their time coming up through the ranks and know first hand of the problems of the physicians and his patients at each level. A rapid rise to a tertiary position removes the physician from his patient for too long and places him in an artificial situation. For example, 80% of all cancer therapy is done by first and second level physicians in their offices and community hospitals, yet management policies and treatment plans are designed by and for tertiary level care. Life, society and practice like a coin sorter will have each woman or man fall into her or his proper niche. Recruitment by incentive should prevail; havenot communities could furnish scholarships, grants in aid or other inducements to obtain the level trained physician of their specific needs. Primary care is a most rewarding way of professional life, but the tertiary professor never exposes his student to this, only to the grandure of tertiary care.

Problem #4. The Individual's Right to Life and Death

Albeit the physician makes the final decision of conserving life or not resisting death, the gray areas which are not spelled out either in his oath or by the ethic of his community make the choices leading up to the final decision most difficult. His personal codes and ethics, those of the community and local society can be at odds with larger or national policies. Society is now aware of the lengths that American Medicine can go to support cellular survival in an organism in which several vital systems or tissues have failed or have ceased to function as an orderly unit. As medical science and research progress, more and more support will be applied to more and more "dead tissues" to maintain a former human from rigor mortis. The mention of

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the word abortion at a cocktail party causes immediate polarization of the assembled guests; this extends out into the entire community as well. Analysis and subsequent guidelines must be promulgated by all three levels of public concern—the national, the state and the community. I favor that the community have the final or ultimate say and its ethic on the individual's rights should be the determining factor to assist the physician in his medical approach to the problem on hand. The unborn human and the uselessly ill human have rights of and to life and death, these are rights yet to be defined and when defined established as changable policy, linked to changing community ethics.

Genetic manipulation to eliminate active disease or to prevent genetic passage of a human defect poses a new challenge to medical and societal ongoing ethical thought. Changes in the gene pool can be considered both advantageous and disadvantageous, but what will the result be ten unborn generations from now? American Medicine or Society can not nor should not isolate from itself genetic problems and patients for observation time is at least one human lifetime by another trained human. Genetic manipulation of non-human life poses altogether different concerns and ethical propositions. New ethics and the principles flowing therefrom must be the physician's and researcher's guide; but which ethics or whose?

Problem #5. Self Policing and Self Pollution

An M.D. degree does not confer virtue, truth and honor on its recipient; these qualities should have been present and obvious to the medical school selection board. Self policing through such mechanisms as CME, PSRO, Mediation Committees, and a reoriented Board of Licensure and Discipline agrees with and conflicts with our Hippocratic Oath. The original oath has had to be modified and modernized to meet changing conditions and times. Its original ethic has been watered down over the centuries. As a profession we best know our strengths and weaknesses and therefore we must be the establishers of all self policing systems or schemes. Outside observers have a built in bias or have an axe to grind. The open forum of organized medicine provides at local, state and national levels, a place in which divergent views can be hammered together into an amiable compromise and then presented to our patients. Your membership and participation in this forum is vital to the continuation of American Medicine, join up!

Preventive medicine, principles of good health and a rational approach to life are not major forces_ in American Medicine; physicians are too busy seeing ill patients. Only recently, has the American physician been furnished with some of the data, knowledge and tools to prevent disease, injury or mental breakdown. American patients are aware of the hazards to health of a cigarette, shot of booze or a fast car; they are less aware of the long term effects of poor diet, occupational diseases and lack of conditioning

exercise. Exposure to this knowledge probably occurred in junior and senior high school when student interest was low and the urge to conform to their society and not general society was high. Adult reeducation is necessary. The stress of modern society and jobholding, the iatrogenically induced disturbances and the toxicity of modern diet represent the hidden hazards of living, which will surface more and more through the next decades. Knowledge as to cause will be manifest, but too late for those of us who have plodded along to make a saving change. The admonition to live a moderate life in all things will have to be modified to exclude certain newly identifiable hazards. Corrections in life style must begin with ourselves.

Problem #6. Government Control and the Bureaucracy

Although the executive branch of the federal government has not promulgated a universal National Health Service, the executive agencies at levels below political appointment have found the way to make their ideas hold, i.e. the mechanism of writing the 'Rules & Regulations' for the congressionally approved laws. The medical profession is being captured by confusion and drowned by superabundance. One individual can not keep up with the deluge of instructions, regulations and rival departmental orders. Even though NHS does not exist as a public law, the physician and American Medicine is being molded step by step, regulation by regulation, such that the "take over" will have been accomplished before it officially occurs. We will have been driven to exclaim, "Let me be, let me treat my patients, you handle the administration, I give up". Organized medicine is now fighting for its life and your professional integrity; it is a battle of retrenchment not an aggressive offense. Whether our defeat is total viz. a technocrat in the Department of Health or partial viz. a physician in a controlled medico-economic system depends what you and the people you can influence do to inform the public/patients and the legislators of your thoughts. Apathy and defeat is synonymous with a technocrat. There are many in our ranks who have already given up. We must cooperate with our medical societies.

Problem #7. Consumer Input and Management of Medical Practice

Since 1964, there have been four major efforts of government to organize the consumer in planning and allocating health care delivery in western Massachusetts. The most recent is entitled the Health Service Agency—HSA. It is a pot pourri of federal, state and regional rules and regulations designed to improve the quality of care while keeping the costs moderate and preventing duplication of services and equipment. By law, the physician and those whom he can influence are excluded from dominance in the decision making activities (a result of our inability to police ourselves). Our expertise in medical practice is shunted out of the discussions and our lesser managerial talents are not allowed to come into play. In what other occupation, business or industry are such restraints applied? Physicians and their allied workers must now seek to influence the HSA committees through an advisory capacity. Since the committees meet during the working day, the physicians will be at a disadvantage. Herein the HDMS can assist its members by keeping track of the meetings and providing a list of physician-advisors or auxiliary-advisors. The ethics involved with this problem are not clear cut but

total exclusion of medical expertise by the HSA will doom the agency, as its predecessors.

Problem #8. Neglected Segments in the Health Care Delivery System

Selected segments of the American population have been found to be lacking access into or deprived of American Medicine. The charge that the physician is to blame for the non-entry or deprivation is not true. Prior to 1965, when government promised to make quality medical care available to the poor and elderly, charity wards and friendly open wards were available for their care. Low income groups and those without Plans A or B also had access to ward care. The best internships and residency programs were to be found in those hospitals with large ward services; it was an honor to be appointed an attending to such an institution. Then the great equalizer, government money, closed the wards and built semi-private accommodations resulting in a need to develop a new system of hospital management and dispersal of staff. Costs climbed. Soon there were more acute care beds than needed and insufficient chronic disease beds. The elderly were isolated (except for the semi) from the rest of the social life of the floor. The sharing and cameraderie of the ward was gone replaced by intercom sets and buzzers. Nurses like physicians were further removed from their patients and the avalanche of paperwork and reports started. Intensive care units brought the nurse back to the patient and acute care is very successful. But rich or poor the care of a new neglected segment has evolved—the chronically ill. Where does the patient go who no longer has family to look after him or who can not fit in or return to active society? The state has withdrawn and the proprietry nursing homes lack compassion and in some adequate trained personnel. Should the ethics of care revert towards open wards again, for some of these neglected patients?

Another segment, which suffers from society's neglect, is those patients who have become dependent upon the machinery of modern medicine. Initial cost and maintenance, plus supporting personnel has resulted in daily care bills approaching $500/day. No adequate payment mechanism is in effect to cover both catastrophic and chronic long term illness; family bankruptcy is not the answer. How much of the "pulling the plug" philosophy is dictated by the wallet and not the heart? As we approach some sort of National Health Policy, society should have decided before enactment the ground rules of operation and the safety checks to contain cost. 1965 must not reoccur. Reducing the percentage of reimbursement, as the unit volume of the physician goes up, may be the quick and easy way to cut up the same pie more ways but it does not take into consideration that the physician is seeing more people and working more and costs all along the line will follow the increased number of processed units. And there will be an increase in processed units, as every society has learned when it offered its citizens *free medical care.* The general level of care and coverage must be defined for American Medicine, if practiced to its fullest and just maintaining current standards will bankrupt the country. Pragmatism will have to override idealism; conservative ethics must override liberal ethics. Physicians

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and organized medicine must stress the fact that our slice of pie has been getting smaller and that increased productivity has contributed to our larger incomes.

Problem #9. Business Principles in the Health Care Delivery System

In the discussion in Problem #8, some principles of business were introduced. All successful business or industry has made sound business principles a cornerstone of operation. The health industry including the physician's office, should be no exception. Few physicians are trained or able in business practice. Usually, when cash in does not equal cash out, fees are raised to a nice round figure higher than before. No attempt at cost analysis or accounting was made and the physician could not logically defend his actions. If he could present to the third party payor, the insurance commissioner or the watchdog agencies a cost sheet detailed to justify a fee increase to cover the increased operating expense of his practice, he would be better able to convince his opponents. We will get no hike if all that is assumed is that the takehome pay has increased, regardless of the fact that home and living costs have also risen for us. Our visible wellbeing draws no sympathy for its improvement. Perhaps the medical society could sponsor several seminars for the "greening of the physicians" through efficient business practices. We often underutilize our accountants.

There is no oath, no ethical principle or position that states an astute physician with solid business and organizational ability, who has managed an efficient operation may not profit thereby, especially if the individual fees are competitive, modest and proper. The local medical society can best judge this and assist in any claims against the membership.

The other major sources for increased costs are the hospitals and the third party payors. They do practice cost accounting and apply business principles to their operations. What is needed is a coordination of efforts and if possible a streamlining of operations. The HSA has been assigned this task. Expansion of outpatient services and preadmission study are two areas in which total costs can be reduced. The hospitals should divide their services into acute, subacute, chronic and longterm care. Per diem charges should then reflect what the patient is receiving and not that a recuperating tonsilectomy must pay for the new cobalt unit or the heart-lung machine. The principle of spreading the cost uniformly may no longer be sound. Nothing need be added to the cost to prevent duplication without full utilization. There is a business ethic of operation called by some capitalism and a medical ethic of providing the best regardless of cost, both of which will have to be rethought. This is society's task to provide the ideas to bring both together so that American Medicine can continue to be second to none.

Problem #10. The Health Personnel Shortage

A simple assumed need for immediate bedside medical assistance under all conditions is not sufficient cause to add large numbers of health personnel to the ranks of the health care delivery team. Planning agencies and governmental philosophers have not been able to calculate accurately how many, where and when, what kinds because society itself does not know. Here again a new health ethic must be developed. Is there justification to keep a general practioner in a

community of 1500 in an area of 500 square miles? Would it be better to staff that town with a nurse practioner or a physician's assistant, a two way radio and helicopter service? The use of emergency medical personnel is expanding to meet the need. Evolution of personnel is happening.

The "maldistribution" of physicians represents the effects of the medical market on the supply of physicians and the lack of a Department of General Practice in the medical schools. Redirection of training programs seems warranted and the state society should be the prime mover with a national coordinating committee. Practice should be directed by those in practice not those in academe. Again the concepts expressed in Problem #3 of leveled training and that the practicing physician should be the concertmaster seem valid. A new profession also may develop that of the physician/administrator, to draw from both disciplines to the patient's and the public's advantage.

Summary

The change of administration which will take place on the 20th of January 1977, mandates an evaluation of the problems facing American Medicine and an expression of attitudes of those who face changes in life or practice styles. In all life's actions and reactions ethics guide us and superego's us. These ethics are not static (even though some were engraved in stone) only the truths from which they are distilled remain unmutable. Change calls for change and the physician must contribute actively thereto; a passive reaction will result in his downgrading to a technocrat.

Ten of the many problems awaiting solution and change in ethical interpretations have been presented: 1) a National Health Policy; 2) the Physician's changing role in the Health Care System; 3) the Training of Ourselves and Our Successors; 4) the Individual's Right to Life and Death; 5) Self Policing and Self Pollution; 6) Government Control and the Bureaucracy; 7) Consumer Input and Management of Medical Practice; 8) Neglected Segments in the Health Care Delivery System; 9) Business Principles in the Health Care Delivery System; 10) the Health Personnel Shortage. Some new and old ideas are evaluated in light of the anticipated changes; related ethics are alluded to. These problems interdigitate and must be related to the many other problems facing the American physician these next four years. The degree to which you put forth your opinions to the legislators, will spell the difference between technocrat or physician.

Conclusions

1) American Medicine will change over these next four years and these changes will influence practice for the rest of this century. Until your retirement.

2) New ethical interpretations of medical truths must be developed to meet the challenge of coming change. Yours are most important.

3) Grass root interpretations should be processed through each level of organized medicine in open forum and the resultant distillate offered to the legislators and executives in the new Congress and administration. A reverse thinktank.

4) Society must provide the direction for the new medical ethics, since it is they who will be affected. Institutions which act as the public or society's conscience must sponsor and lead in the discussions. As was done in 1776.

The Editor-in-Chief

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